

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 0 — 2 3 MA

2. STATE:

New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)
Title XIXTO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

October 1, 2000

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 430.12(c), P. L. 106-169

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$540 thousand

b. FFY 2002 \$540 thousand

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 1 to Attachment 2.2-A
Page 1

*** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

Same

10. SUBJECT OF AMENDMENT:

Reasonable Classification of Individuals Under the Age of 21, 20, 19, and 18

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:

Exempt pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Michele K. Guhl

14. TITLE:

Commissioner

15. DATE SUBMITTED:

10/28/00

16. RETURN TO:

Division of Medical Assistance
and Health Services

P.O. Box 712

Trenton, NJ 08625-0712

Revision:

Attachment 2.2A
Page 23f
OMB No. : 0938-

State/Territory: New Jersey

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(10)(A)
(ii)(XVII) of the Act

26. ☒ Young people under age 21 who were in foster care under the responsibility of the State on their 18th birthday, regardless of income and resources.

TN 00-23 Approval Date MAY 29 2001
Supersedes TN **New** Effective Date 001 01 2000

TN No. _____ Approval Date _____ Effective Date _____
Supersedes
TN No. _____ HCFA ID: 7983E



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Refer to DMSO: JA

JUN 06 2001

Region II
Federal Building
26 Federal Plaza
New York, NY 10278

Deborah C. Bradley, Acting Director
Division of Medical Assistance and Health Services
Department of Human Services
P.O. Box 712
Trenton, New Jersey 08625

Dear Ms. Bradley:

HCFA has reviewed your letter of May 15, 2001, in which you responded to our concerns about New Jersey State Plan amendment 95-32. This amendment updates the reimbursement methodology for governmental psychiatric hospitals. State Plan amendment 95-32 is approved, with an effective date of July 1, 1995. As requested in your letter, we are substituting the revised page numbered Attachment 4.19A, page II-1 for the page originally submitted.

Copies of the signed HCFA-179 and the approved page are enclosed. If you or your staff members have any questions, please contact Julie Alberino at 212-264-3904.

Sincerely,

A handwritten signature in cursive script, appearing to read "Sue Kelly", is written over the typed name.

Sue Kelly
Associate Regional Administrator
Division of Medicaid and State Operations

cc: F. Wish

Enclosure

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7. FEDERAL BUDGET IMPACT:

a. FFY _____ \$ _____
b. FFY _____ \$ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

*** SEE REMARKS

10. SUBJECT OF AMENDMENT:

Revised Psychiatric Services for the Developmentally Disabled
in Adult Services for the Developmentally Disabled

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ OTHER, AS SPECIFIED:

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:

16. RETURN TO:

13. TYPED NAME:

14. TITLE:

15. DATE SUBMITTED:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **SEP 27 1995**

18. DATE APPROVED: **JUN 06 2001**

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

07/01/95

20. SIGNATURE OF REGIONAL OFFICIAL:

Sue Kelly

21. TYPED NAME:

Sue Kelly

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS: As per stated in letter received from State on 05/15/01 Attachment 4.19A page II-1
has been revised and is now approved

REIMBURSEMENT FOR GOVERNMENTAL (STATE AND COUNTY) HOSPITALS PROVIDING INPATIENT PSYCHIATRIC SERVICES OR ACUTE CARE PATIENT SERVICES FOR THE DEVELOPMENTALLY DISABLED

- I. A. Governmental hospitals are hospitals owned or operated by State or County governmental agencies that provide long-term inpatient psychiatric services or acute care services for developmentally disabled patients.

B. Private Psychiatric Hospitals are those psychiatric hospitals not owned or operated by State or County government agencies.

C. Long Term Care Psychiatric Hospitals are governmental or private psychiatric hospitals enrolled in the New Jersey Medicaid program as a long term care provider based on the average length of stay of its patients.

- II. Reimbursement for governmental inpatient hospital psychiatric services and acute care inpatient hospital services for the developmentally disabled is based upon Medicare principles for determining reasonable cost reimbursement described in 42 CFR Part 413.

For Long Term Care Psychiatric Hospitals, clothing, indicated in a patient's plan of care is an allowable cost for Medicaid patients.

- III. Upper limits of reimbursement will be the lower of reasonable costs of services described above or the provider's customary charges to the general public.

- IV A retrospective reimbursement system is being utilized.

Interim per diem rates are based upon actual cost and statistical data contained in the most current Medicare/Medicaid Cost Report (HCFA 2552) plus a factor for inflation. In those instances where the prior year cost report data plus an inflation factor does not serve as an accurate base for the billing period rate, a base year adjustment (cost and/or statistical) shall be made to more accurately reflect the anticipated rate for the billing periods.

Final reimbursement (settlement) amounts are based on actual cost and statistical data for the service period which reflect the standards and principles identified in Paragraph II. These amounts will reflect the difference between the reimbursement received by the provider based on the interim rates in effect for the service period and the final rates which are based on the actual Medicare/Medicaid Cost Report (HCFA 2552) for the service period.

Interim rates and final settlement amounts are approved by the Director of Division of Medical Assistance and Health Services or his/her designee.

95-32-MA (NJ)

Supersedes 90-12-MA (NJ)

TN 95-32 Approval Date JUN 06 2005
Supersedes TN 90-12 Effective Date JUL 01 1995